VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 1, 2016

Mr. Dan Daly, Manager
The Residence At Shelburne Bay West
185 Pine Haven Shore Road
Shelburne, VT 05482-7805

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 20, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0589	A. BUILDING: _____ B. WING _____	C 01/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY WEST	185 PINE HAVEN SHORE ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensure survey was completed on 1/20/16 by the Vermont Division of Licensing and Protection. The survey also included a review of the facility's mandatory self-reports. The following regulatory violations are related to the re-licensure survey. There were no violations related to the self-reports.	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident was reassessed annually and at any time when there was a change in condition for 1 of 5 residents in the sample. (Resident #4). Findings include: Per review of the medical record for Resident #4 on 1/20/16, the most recent full resident assessment was dated 4/29/14, coded as the annual assessment. The next full assessment was due on or before 4/29/15. The lack of required annual reassessment was confirmed with the Registered Nurse (RN) and the Reflections Program Director on the afternoon of 1/20/16.	R136	R136 A Resident Assessment has been completed for Resident #4 Resident charts were audited to ensure that resident assessments were completed annually. Audits will be done quarterly to ensure that resident assessments are being done annually. Results from the audits will be reviewed by the communities Quality Assurance team. ED/HSD to monitor to ensure compliance.	2/20/16

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

2/12/16

STATE FORM 6899 EB6S11 If continuation sheet 1 of 6

R136 - R302 POCs accepted 7/28/16 MBoltonRN/PMC

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R150	Continued From page 1	R150		
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that resident accidents/incidents were documented in the record at the time of the occurrence, along with action taken for 2 applicable residents in the sample. (Residents #1 and #6). Findings include: Per review of a facility mandatory report to the licensing agency and interview with the unit's Director, there was a physical resident to resident incident on 1/18/16 between the two residents. Although staff took appropriate actions to assure the resident's safety and documented the incident in an event report, nursing staff failed to document the incident, and actions taken, in each resident's medical record, per review of the records on 1/20/16. The lack of documentation was confirmed during interview with the RN Charge Nurse and the Director on the afternoon of 1/20/16.	R150	Late entry documentation was completed for residents 1 and 16. Incident reports for that week were reviewed and notes were written for all events that week. Audits will be completed weekly for one month to ensure nurses notes are written for all incidents. Audits will be completed monthly for documentation of incidents afterward. These audits will be reviewed at the communities QA meetings. ED/HSD to monitor to ensure compliance.	2/29/16
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures:	R247		2/20/16

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R247	Continued From page 2 (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that perishable foods were labeled and dated related to 2 items stored in the refrigerator. Findings include: Per observations during a tour of the main kitchen on the afternoon of 1/19/16, the following items were seen in the walk-in refrigerator: a section of prosciutto, rewrapped from the original packaging and not dated, and a container marked "stew", dated 1/7/16. During interview, the Food Service Director (FSD) confirmed that refrigerated foods must be labeled and dated and must be disposed of after 7 days.	R247	FSD threw out those items during a later tour with the ED. Inservices which will involve all culinary staff have been initiated and will be completed by 2/20/16 (including per diems). Staff educated on dating/FILO policy. ED/FSD to ensure compliance and audits will be reviewed at the Communities QA meetings.	2/20/16
R253 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines This REQUIREMENT is not met as evidenced by: Per observations during a tour of the main kitchen on 1/19/16, the following areas and food service equipment were not maintained in a sanitary manner: 1. The free standing convection ovens had a build-up of visible grease and food debris on the	R253		

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R253	Continued From page 3 front areas of the equipment. 2. The side of the food steamer was visibly soiled, and a work table next to the stove was heavily soiled on the lower shelf. 3. Two baker's racks had a build up of food debris on the shelves. 4. The storage shelf under the butcher block unit was soiled. 5. The storage shelf under the slicer unit was soiled. 6. The floors had 2 areas where breaks in the flooring surfaces had been covered with masking tape, which was not intact and not a suitable fix for the damaged flooring. The tape was torn and subflooring exposed; the surfaces were not smooth, intact and cleanable. The observations were confirmed by the FSD who accompanied the surveyor on the tour.	R253	All reported areas have been cleaned and organized. a daily check sheet is now used by staff to ensure compliance. Check sheets monitired x5 per week by FSD, and results brought to the communities QA committee. Quote obtained to fix flooring which will be completed by 2/10/16	
R259 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.i Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that poisonous chemicals were appropriately stored in a food storage area. Findings include: Per observations of the dry food storage areas,	R259	inservicing scheduled for culinary staff in regards to cleaning schedules. FSD/ED responsible to ensure compliance. R259 those chemicals now stored in a locked compartment. FSD to check 5 days a week to ensure those materials are kept in the	2/29/16

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R259	Continued From page 4 poisonous chemicals (cleaning supplies) were stored adjacent to foods on shelving in the food storage room. The chemicals were not kept in a separate locked compartment, as required if they are to be in the same food storage area. The observations were confirmed with the FSD and the ADM during the afternoon of 1/19/16.	R259	audits will be performed weekly to ensure compliance and the results of those findings will be brought to the communities QA committee.	
R302 SS=C	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that there was documented evidence of the required fire drills conducted at least quarterly and at the four specified times of the day. Findings include: Per review of the fire drills for the past 12 months, the ADM (administrator) was able to show evidence of only one drill, conducted during December, 2015. The ADM stated during	R302	FSD/ED to monitor to ensure compliance. A recent fire drill has been conducted, and the community will have them at least quarterly for all shifts. ED/Maintenance Director will ensure compliance, and monthly audits will be completed to ensure all associates have attended the necessary fire drills. these audits will be brough to the QA committe to ensure compliance.	2/20/16

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R302	Continued From page 5 interview that although the drills had been done, s/he was not able to locate the written documentation to show evidence of the process.	R302		